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REIMAGINING HEALTH GOVERNANCE IN THE POST-COVID-19 ERA: LEGAL LESSONS, POLICY GAPS, AND FUTURE DIRECTIONS

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Abstract

The COVID pandemic showed the inherent drawbacks in the global and national health governance frameworks and presented serious gaps in the legal frameworks, coordination systems, and preparedness infrastructure. This article examines the legal and policy lessons learned from the pandemic response, analysing emergency powers, human rights implications, and governance failures across multiple jurisdictions. This paper explores the legal and policy lessons that have been learned throughout the pandemic response process, including the emergency powers, the impact of human rights, and the failures of governance in various jurisdictions. The article suggests a complete reassessment of the health governance framework, including the legally obligatory preparedness, the stronger role of WHO, combined surveillance systems, and human rights-based emergency response. This study will provide practical suggestions on how to create resilient, fair, and legally strong health governance systems to counter possible future pandemics and protect democratic values and basic rights.

Keywords: COVID-19 Pandemic, National Health Governance, International Health Law, Emergency Powers, WHO.

1. Introduction

The pandemic is an unprecedented worldwide epidemic of health, which has radically questioned the existing conceptualizations of health governance on the national and international levels.[1]The pandemic has claimed millions of lives, crippled economies all over the world, and revealed fundamental structural frailties in health systems in both the

[1] Devi Sridhar, *Preventable: The Politics Of Pandemics And How To Stop The Next One* 15-34 (Penguin Random House 2022).

undeveloped and developed countries.[2] The pandemic has brought about deeper doubts than just the suitability of the legal regimes in dealing with epidemics, the connection between state and individual rights and the efficacy of international co-ordination mechanisms.

The concept health governance is an umbrella term referring to the intricate network of actors, institutions, norms and processes that determine collective action in relation to health issues.[3] These involve the national health systems, international agencies like WHO, legal and regulatory framework, financing mechanisms as well as the determinants of health at large which comprise social, economic, and environmental factors. The pandemic exposed that this system of governance, formulated in reaction to past epidemiological calamities, was inefficient with a fast spreading respiratory illness in our globalized society.

The pandemic has generated three dimensions of governance failure which are critical. To begin with, the ***legal aspect*** showed that the emergency powers structures in most jurisdictions did not have explicit restrictions, time limits, and accountability, which raised the issues of democratic backsliding and human rights abuses.[4] Second, the ***institutional aspect*** exhibited disintegrated authority, lack of co-ordination among the several governmental tiers, and inability to make timely decisions in times of uncertainty. Third, the ***global aspect*** revealed the low power of the WHO, the ineffectiveness of the International Health Regulations as the instrument of governance, and the lack of proper mechanisms ensuring international collaboration and equal distribution of resources.[5]

This paper provides an in-depth overview of the health governance issues revealed by COVID-19, considers the legal lessons, pinpoints the on-going policy gaps, and suggests the areas of reform in the future. It is based on comparative legal examination of various jurisdictions, international law, research in the field of public health policies and empirical data on responses to pandemic. The overarching point is that to have efficient health

[2] Adam Tooze, *Shutdown: How Covid Shook The World's Economy* (Penguin Press 2021).

[3] Lawrence O. Gostin, 'The Future of the World Health Organization: Lessons Learnt from Ebola', (2015) 93(3) *The Milbank Quarterly* 475–479; Julio Frenk, 'Governance Challenges in Global Health' (2013) 368 *New England Journal of Medicine* 936-942.

[4] Tom Ginsburg & Mila Versteeg, 'The Bound Executive: Emergency Powers During the Pandemic' (2021) 19(5) *International Journal Of Constitutional Law* 1498-1535.

[5] Gian Luca Burci & Jakob Quirin, 'Implementing the International Health Regulations (2005)—A Call for Renewed Political Commitment' (2020) 46(2-3) *American Journal Of Law & Medicine* 199.

governance to address future pandemics, there has to be more than just some improvements but rather a radical re-thinking of the legal systems, institutions, and mechanisms of global cooperation.

The article is divided in four sections. Part II discusses the legal lessons of the pandemic, emergency powers, the role of human rights and national differences in reaction to the pandemic. Part III reveals the key policy deficits in the sphere of surveillance, coordination, resources distribution, and accountability. Part IV suggests the possible way forward in how health governance can be reformed, in terms of certain legal and institutional innovations. Part IV gives a framework of implementing these reforms. The article finishes with the note of a pressing necessity of a governance transformation in the time of a growing pandemic risk.

2. Legal Lessons from the Pandemic

A. Rule of Law and Emergency Powers

The declaration of emergency authority regarding COVID-19 demonstrated some inherent contradictions between the imperative of good health and constitutional governance.[6] Governments all over the world used emergency declarations in democracies in order to circumvent the usual legislative procedures, restrict movement and assembly, and provide mandatory medical procedures. Although the emergency in the domain of healthcare might require a quick intervention of the government, the pandemic showed that numerous legal frameworks were not sufficient to restrict the power of the executive or introduce any substantial control.

Table 1: Comparative Analysis of Emergency Legal Frameworks

Jurisdiction	Legal Basis	Duration Limits	Legislative Oversight	Judicial Review	Sunset Provisions
India	The Disaster Management Act of 2005 and the Epidemic	No specific limit in EPA; DMA allows extended periods	Limited parliamentary oversight during emergency	Available but rarely invoked during pandemic	Weak sunset provisions

[6] Bruce Ackerman, 'The Emergency Constitution' (2004) 113(5) *Yale Law Journal* 1029.

	Diseases Act of 1897				
United Kingdom	Civil Contingencies Act 2004; Public Health Acts	30 days renewable; extended through primary legislation	Parliamentary approval required for extensions	Judicial review available	Yes, but extended through new legislation
United States	Public Health Service Act; state emergency powers	Varies by state; federal renewable every 90 days	Limited during emergency; post-hoc review	Available but limited during emergency	Generally yes, but extended repeatedly
European Union (selected states)	National constitutions; EU public health competencies	Germany: 6 months; France: 1 month renewable	Germany: strong Bundestag role; France: Parliamentary approval after 1 month	Generally robust	Yes, but frequently renewed
Brazil	Federal Constitution Art. 196; Law 13.979/2020	No specific constitutional limit	Congressional oversight theoretically required	Judicial review active	Provisions tied to WHO emergency declaration

The comparative analysis indicates the great divergence in the strength of legal protection. The constitutional system used in Germany, where the Bundestag needs to approve such an emergency and where the judiciary is particularly vigilant, is quite contrary to the jurisdictions where the emergency powers were repeatedly granted with little legislative input.[7] The experience of the United Kingdom showed the benefits of having strict statutory

[7] Christoph Möllers, 'Parlamentarische Kontrolle in der Corona-Pandemie' (*Verfassungsblog*,26 March 2020).

frameworks, as well as the dangers of the continued regime of emergencies that becomes normalized.[8]

One of the most important lessons learned is that legislation of emergency powers should include a few key conditions: (1) precise triggering requirements in terms of objective health indicators; (2) automatic time out conditions with high possibilities of renewal; (3) mandatory legislative monitoring and approval of extensions; (4) protection of fundamental rights that cannot be suspended; and (5) enhanced and not suppressed judicial scrutiny in times of emergency.[9] But the pandemic demonstrated that, in the absence of these protections, emergency powers may be used as a means to uphold an authoritarian regime, but no longer as a tool of legitimized public health actions.

B. Human Rights Implications and Proportionality

Some of the most enormous limitations of the fundamental rights were imposed during the pandemic response.[10] Although the IHR Law allows restrictions of rights in times of public health emergence, the restrictions should satisfy the legality, necessity, proportionality, and the non-discrimination tests.[11]Those systemic failures to exercise these principles strictly were revealed during the COVID-19 response.

These tensions are demonstrated through contact tracing technologies. Although it is potentially valuable in controlling epidemics, most jurisdictions had been using surveillance systems without sufficient legal frameworks, privacy protection, or transparency.[12]The application of mobile phone data, facial recognition, and compulsory tracking applications triggered the issue of mission creep and normalization of surveillance infrastructure.

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[8] Jeff King, 'Constitutional Principles and Restrictions in the United Kingdom During COVID-19' in Tom Ginsburg & Mila Versteeg (eds.), *Comparative Constitution Project: Constitutions And Contagion* 78 (2021).

[9] Aharon Barak, *Proportionality: Constitutional Rights and Their Limitations* (2012).

[10] Amnesty International, *Amnesty International Report 2021/22: The State of The World's Human Rights* 23-45 (2022)..

[11] UNHRC, *The Siracusa Principles on the Limitation and Derogation Provisions in the International Covenant on Civil and Political Rights*, UN Doc. E/CN.4/1985/4 (September 1984); UNHRC, *CCPR General Comment No. 29: Article 4: Derogations during a State of Emergency* UN Doc. CCPR/C/21/Rev.1/Add.11 (2001).

[12] Michael Veale, Reuben Binns, Lilian Edwards, 'When Data Protection by Design and Data Subjects' Rights Clash' (2018) 8 *International Data Privacy Law* 105.

Countries such as South Korea adopted considerably transparent and time-bound regimes whereas others created more coercive regimes with uncertain dates of termination.[13]

Although well-grounded epidemiologically, lockdown measures in most cases, failed proportionality tests, either being too general, lacking in specificity, or continued to exist even after the need no longer existed.[14]The implementation also reflected differences, where the marginalized groups were met out disproportionately with the police and other fines. The moral of the story is that emergency actions should be re-evaluated against changing scientific evidence and modified or abandoned as unnecessary.

Another complicated human rights issue was the problem of vaccine mandates. As long as courts in most jurisdictions found mandatory vaccination or vaccine passports were reasonable steps to take towards the public health,[15] the actual implementation process was, in many cases, not nuanced in terms of the medical exemptions, religious accommodation, and employment and social participation impacts. The future systems of governance should enhance balance of collective health protection and individual autonomy as well as establish strict guidelines on when mandate is appropriate and where mandate should be lifted.

C. Federalism and Multi-Level Governance Challenges

Specific tensions were felt in federal systems because national and subnational governments tended to take opposing courses towards the pandemic.[16] The United States was a vivid example of these issues, having a sharp difference in state responses, a conflict between states on the resource distribution and control over the regulations and the misunderstanding of which governmental tier had the final power to decide how to act during the pandemic.[17]

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[13] Sharon Bassan, 'Data privacy considerations for telehealth consumers amid COVID-19' (2020) 7(1) *J Law Biosci lsaa075*.

[14] UN Human Rights Office of the High Commissioner, *Emergency Measures and COVID-19: Guidance* (26 April 2020).

[15] Roman Boed, 'State of Necessity as a Justification for Internationally Wrongful Conduct' (2000) 3 *Yale Human Rights And Development Law Journal* 1.

[16] Ann Althouse, 'Federalism, Untamed' (1994) 47 *Vanderbilt Law Review* 1207.

[17] Katherine W. Bauer et al., 'A Safety Net Unraveling: Feeding Young Children During COVID-19' (2021) 111(1) *American Journal of Public Health* 116–120.

The experience of the Canadian showed how powerful and weak cooperative federalism can be during health emergencies. While provincial autonomy allowed for tailored responses, it also created border control challenges, procurement competition, and inconsistent public health messaging.[18] The moral is that federal governments need to be better defined in terms of power in health crises, including:

- Constitutional or statutory provisions clearly allocating powers between levels of government.
- Systems of compulsory coordination and information exchange.
- Federal criteria defining the minimum types of protection but leaving jurisdiction flexibility.
- Inter-governmental dispute resolution.
- Assured non-political flow funding.

Even unitary states could not escape coordination problems as the relations between national governments and local authorities in such nations as France and Italy proved. The most important thing learned is that proper health governance must be characterized by an understanding of authority, obligatory coordination mechanisms and the concept of subsidiarity to make decisions at the right level of government.[19]

D. International Law and the Limitations of the IHR

The main international tool in the response to pandemics is the IHR (2005).[20] But, the COVID revealed how this framework was critically weak. The IHR mandates states to establish fundamental surveillance and responding capabilities, alerts WHO of possible public health emergencies, and prevent the unnecessary disruption of global traffic. Nonetheless, there are poor compliance mechanisms and the laws have no teeth.

Some loopholes were noticed in law. First, the notification stipulations of the IHR depend on the self-reporting by the states, which generates motivation towards latency in disclosure in

[18] Patrick Fafard & Steven J. Hoffman, 'Rethinking Knowledge Translation for Public Health Policy' (2020) 16(1) *Evidence and Policy* 165-175.

[19] George A. Bermann, 'Taking Subsidiarity Seriously: Federalism in the European Community and the United States' (1994) 94 *Columbia Law Review* 331.

[20] WHO, *International Health Regulations* (2005) (3rd edn. WHO) (15 June 2007).

order to avoid both economic and reputational expenses.[21] Second, the rules lack a process to make states exchange viral samples, genomic information, and research results, which prevents international scientific cooperation. Third, the authority to declare a PHEIC by WHO, is not coupled with the power to impose national measures and international response.[22]

The insufficiency of the current international legal frameworks in guaranteeing fair access to the medical countermeasures was also highlighted in the pandemic. Although a call exists to have a people vaccine, intellectual property regimes and an absence of binding commitments related to technology transfer provided enormous differences in access to vaccines between low and high income countries.[23] The moral is that the international health law needs to transform into the form of voluntary cooperation to a system of binding obligations, enforcement, and equitable resource distribution requirements.

3. Critical Policy Gaps Revealed by the Pandemic

A. Surveillance and Early Warning Systems

The response to pandemic largely relies on the early detection and characterization of new pathogens. COVID-19 showed the existence of critical lapses in the world surveillance architecture. Although the world invested in the aftermath of SARS and H1N1, there were numerous countries where they did not have an effective surveillance system that could identify abnormal disease trends.[24] Even in cases where there were early warning signals as happened in late 2019, the international systems through which investigation and verification could have been achieved were not effective.

Table 2: Policy Gaps in Pandemic Preparedness and Response by Domain

Domain	Specific Gaps Identified	Consequences During COVID-19	Reform Priority

[21] Lawrence O. Gostin, Mary C. DeBartolo, Eric A. Friedman, 'The International Health Regulations 10 Years On: The Governing Framework for Global Health Security' (2015) 386 *The Lancet* 2222-2229.

[23] Matthew Kavanagh, Ngozi A. Erondu, et al., 'Access to Lifesaving Medical Resources for African Countries: COVID-19 Testing and Response, Ethics, and Politics' (2020) 395 *The Lancet* 1735-1740.

[24] Jennifer B. Nuzzo, Diane Meyer, et al., 'What Makes Health Systems Resilient Against Infectious Disease Outbreaks and Natural Hazards?' (2019) 19(1) *BMC Global Health*.

Surveillance & Early Warning	• Inadequate genomic sequencing capacity • Weak animal-human interface monitoring • Lack of real-time data sharing platforms • Insufficient laboratory networks	• Delayed pathogen identification • Inability to track variants • Poor understanding of transmission dynamics	Critical
Coordination Mechanisms	• Unclear command structures- • Poor inter-agency communication • Lack of pre-established protocols • Minimal private sector integration	• Conflicting public health guidance • Duplicated efforts- Slow decision-making	High
Resource Allocation	• No strategic reserves framework- • Absence of surge capacity planning- • Weak supply chain resilience- • Inequitable	• PPE shortages- • Ventilator scarcity • Vaccine nationalism • Health worker burnout	Critical

	distribution mechanisms		
Scientific-Policy Interface	• Limited rapid research coordination- • Weak evidence synthesis mechanisms- • Poor science communication systems- • Insufficient advisory body diversity	• Conflicting public guidance- • Slow protocol updates Public confusion and mistrust- Delayed policy adaptation	High
Accountability	• Absence of performance metrics- • Weak transparency requirements- • Limited evaluation mechanisms- • No international compliance monitoring	• Inability to assess response effectiveness- • Unchecked emergency powers • Limited learning for future events	Medium
Financing	• Inadequate preparedness funding • No pandemic insurance mechanisms	• Delayed vaccine development- • Insufficient response capacity- • Economic	Critical

	• Weak sustainable financing structures- • Limited global pooled funds	devastation- Fiscal stress on health systems	

The policy gap extends beyond technical capacity to legal and institutional frameworks. Many jurisdictions did not have the statutory power to require syndrome surveillance data reporting that would have facilitated real-time situational awareness. The exchange of international data was voluntary and not regular and lacked legal mandates and uniform formats.[25]There was the inability to combine environmental, animal and human health surveillance so that the spill over risks of zoonotic threats was not properly tracked.

To fill this gap, there must be: legal requirements to have comprehensive surveillance and with privacy protection; international platforms of real-time data sharing with binding participation requirements; investment in laboratory networks and genomic sequencing capacity in the world; and One Health surveillance systems, which monitor emergence of pathogen at the animal-human-environment interface.[26]

B. Coordination and Command Structures

The pandemic revealed disjointed command systems in most jurisdictions, where authority was unclear, neither mandates nor coordination among health agencies, emergency management systems, and other government bodies. In the US, the disputes between CDC, FDA, state health departments, and the White House Coronavirus Task Force caused confusion and inconsistency in the implementation of policies. Other federal systems as well as even in unitary states experienced similar failures of coordination.

The private sector integration gap proved particularly problematic. Although the control of key resources such as the capacity to perform diagnostic tests, and the manufacturing of

[25] Alexandra L. Phelan, 'COVID-19 Immunity Passports and Vaccination Certificates: Scientific, Equitable, and Legal Challenges' (2020) 395 *The Lancet* 1595-1598.

[26] Jakob Zinsstag, Esther Schelling, et al., 'From 'Two Medicines' to 'One Health' and Systemic Approaches to Health and Well-Being' (2011) 101 *Preventive Veterinary Medicine* 148.

therapeutic materials were under the jurisdiction of private parties, very few jurisdictions had structures by which they could coordinate with the public in case of a health emergency. This led to slow implementation of the capabilities of the private sector and ineffective use of resources.[27]

There was also failure of international coordination mechanisms. The WHO did not have the powers to adequately coordinate the national responses, and the multilateral forums that were present were inefficient in the handles of the global aspects of the pandemic. Lack of the previously established methods of organizing research, resources, and policies coordination implied that the work was redundant, ineffective, and counterproductive in most cases.[28]

C. Strategic Reserves and Supply Chain Resilience

The shortage of personal protective equipment (PPE), ventilators, and subsequent vaccines showed how the lack of strategic reserves policies and planning of supply chain resiliency.[29] The majority of the nation's held small stockpiles, used the just in time supply chains, which are easily compromised, and did not have any structures of surge capacity production. The ensuing shortages were threatening to the healthcare personnel, made medical services more difficult, and generated undignified international resource competition.

The policy gap goes down to legal frameworks. Not many jurisdictions were mandating production priorities, resource allocation, and export hoarding using statutory authority. The international law did not offer a way of making sure there is a fair distribution or being in line with preventing vaccine nationalism.[30] The COVAX facility, however, well-intended, did not have the means and power to enforce fair access to immunizations on a worldwide.

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[27] Marc Lipsitch, Lyn Finelli, et. al., 'Improving the Evidence Base for Decision Making During a Pandemic: The Example of 2009 Influenza A/H1N1' (2011) 9(2) *Biosecur Bioterror.*

[28] Suerie Moon, Devi Sridhar, et al., 'Will Ebola change the game? Ten essential reforms before the next pandemic. The report of the Harvard-LSHTM Independent Panel on the Global Response to Ebola' (2015) 386 *The Lancet* 2204-2221.

[29] Prashant Yadav, 'Health Product Supply Chains in Developing Countries: Diagnosis of the Root Causes of Underperformance and an Agenda for Reform' (2015) 1(2) *Health Systems & Reform* 142-154.

[30] Thomas J. Bollyky & Chad P. Bown, 'The Tragedy of Vaccine Nationalism: Only Cooperation Can End the Pandemic' (2000) 99(5) *Foreign Affairs* 96.

To eliminate this gap, there is need to: establish strategic reserves that are legally compulsory and regularly replenished; establish domestic surge manufacturing capacity; establish international agreements that impose binding obligations on equitable resource allocation; establish supply chain diversification requirements; and establish new international institutions with the mandate of coordinating the creation and dissemination of medical countermeasures.[31]

D. Accountability and Transparency

The lack of mechanisms of accountability to pandemic governance decisions was probably the most worrying gap. Most of the governments were less transparent, less accessible to information and less subject to scrutiny in the course of the emergency times.[32] Comparative assessment and learning was hard because standardized measures of effective response evaluation had not been established. In the absence of agreed measures of success or post-action review frameworks, precious lessons will be learned.[33] At the international level, there were no mechanisms of keeping states accountable to IHR violations or lack of good performance during pandemics.

The future governance systems should incorporate the accountability by: the obligatory transparency of all emergency decisions; the parliamentary scrutiny that should be in force even in the emergencies; the uniformity of performance measurements; the obligatory post-incident reviews; and the internationalization of accountability with the consequences of non-adherence being real.

4. Future Directions for Health Governance Reform

A. Strengthening International Legal Architecture

The weaknesses of the IHR drive the need to reform the international law on health. There are a number of proposals that are worth considering. To begin with, a ***Pandemic Treaty*** that is being negotiated at WHO may create binding requirements on preparedness such as

[31] Independent Panel For Pandemic Preparedness And Response, *Covid-19: Make It The Last Pandemic* (May 2021).

[32] Open Government Partnership, *Collecting Open Government Approaches to COVID-19* (2020).

[33] Jennifer B. Nuzzo, Lucia Mullen, Matthew Snyder, et al., *Preparedness For A High-Impact Respiratory Pathogen Pandemic* (Johns Hopkins Center For Health Security 2019).

minimum capacity standards, compulsory information exchange, and fair provision of medical countermeasures.[34]

Second, the authority of WHO should be strengthened, such as the ability to perform independent investigations without the permission of the host state, the ability to declare the regional or sectorial emergency, and the ability to coordinate the international response with the mandatory involvement of states..[35]

Third, the technology transfer, the local manufacturing capacity building, and the pooled procurement mechanisms as a tool of attaining the equity aspect in the international law have to be binding to the low-income countries so that they can be able to acquire the medical countermeasures in times of an emergency.[36]

Table 3: Proposed Health Governance Reforms Matrix

Reform Area	**Current State**	**Proposed Innovation**	**Implementation Mechanism**
International Legal Framework	Voluntary IHR with weak enforcement	Binding Pandemic Treaty with enforcement mechanisms	WHO negotiation process; domestic ratification
WHO Authority	Limited investigation/coordination	Enhanced powers for independent investigation; binding coordination authority	Constitutional amendment or new specialized agency
Surveillance	Fragmented national	Integrated global	International

[34] WHO, 'Member States Agree to Develop Zero Draft of Legally Binding Pandemic Accord' (7 December 2022); Lawrence O. Gostin & Ana Sumei Ayala, 'Global Health Security in an Era of Explosive Pandemic Potential' (2017) 9 *Journal of National Security Law & Policy* 53.

[35] Mark Eccleston & Harry Upton, 'International Collaboration to Ensure Equitable Access to Vaccines for COVID-19: The ACT-Accelerator and the COVAX Facility' (2021) 99(2) *Milbank Quarterly* 426-449.

[36] Brook K. Baker, 'Trans-Pacific Partnership Provisions in Intellectual Property, Transparency, and Investment Chapters Threaten Access to Medicines in the US and Elsewhere' (2016) 13(3) *PLOS Medicine*.

Systems	systems	platform with mandatory real-time reporting	agreement; digital infrastructure investment
Emergency Powers	Highly variable national frameworks	Model legislation with rights protections and oversight	National legislative reform; comparative best practices
Resource Allocation	Market-based with national hoarding	Pooled procurement; equitable distribution mandates	International agreements; new financial mechanisms
Financing	Ad hoc emergency funding	Pandemic Fund with steady-state financing ($10B annually)	Donor commitments; innovative financing (e.g., taxation)
Research Coordination	Competitive, fragmented	Global research coordination mechanism with data sharing mandates	WHO or new body; funding conditionality's
Accountability	Weak transparency and review	Mandatory performance metrics; independent review bodies	National legislation; international monitoring mechanism
Community Engagement	Minimal institutionalization	Structured engagement mechanisms in governance	National public health law reform; capacity building

B. Reimagining National Health Governance

Health governance at the national level should be reorganized on a number of principles. First, ***integrated preparedness planning*** ought to be legally obligatory with requirements of frequently revised pandemic plans, exercise response procedures, and surge capacity maintained. They should be legislated to create independent preparedness review bodies, which can review the national preparedness and publicly report on gaps.[37]

Second, the ***emergency powers systems*** have to be reformed to reflect the lessons mentioned in Part II. Best practice legislation ought to contain: objective, unambiguous basis of emergency declarations; automatic expiry provisions subject to supermajority need of renewal; requirement of legislative approval of any extension to initial term; protection of fundamental rights such as right of speech, right of assembly (with qualitative narrowing), and access to the courts; and increased judicial review, such as expedited means of appealing against emergency measures.[38]

Third, national health institutions need ***updated governance frameworks*** such as the establishment of clear statutory mandate, isolation of science-based decisions, increase in the transparency requirement, and improved advisory processes that capture the various views such as bioethics, social sciences, and community members.[39]

C. Building Resilient Health Systems

The reform of governance should not be limited to the emergency response but needs to focus on the fundamental health system vulnerabilities. In addition to being a development objective, universal health coverage is essential for pandemic preparation. During COVID-19, nations with strong primary care systems and universal coverage often fared better.[40]

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[37] Jennifer Kates, Josh Michaud, et. al., 'Comparing Trump and Biden on COVID-19' *Kaiser Family Foundation* (September 2020).

[38] Kim L. Scheppele, 'Autocratic Legalism' (2018) 85(2) *University Of Chicago Law Review* 545; Ozan O. Varol, 'Stealth Authoritarianism' (2015) 100 *Iowa Law Review* 1673.

[39] Sheila Jasanoff, *The Fifth Branch: Science Advisers As Policymakers* (Harvard University Press, 1998).

[40] Thomas J. Bollyky, Erin N Hulland, et al., 'Pandemic Preparedness and COVID-19: An Exploratory Analysis of Infection and Fatality Rates, and Contextual Factors Associated with Preparedness in 177 Countries' (2022) 399(10334) *The Lancet* 1489-1512.

Government systems must legally require movement towards universal coverage and accountability systems.

Another important dimension is the workforce capacity. The pandemic showed how poorly public health professionals, epidemiologists and trained healthcare workers were short. This should be reformed in the way of mandatory workforce planning, investments in education pipeline, and reserve corps designs that can be mobilized in case of emergency.[41]

D. Digital Health Infrastructure and Data Governance

The pandemic increased the pace of digital health adoption, as well as demonstrated the gaps in governance in this sphere. These issues will have to be considered the future of health governance: (1) interoperability of health information systems to allow the sharing of data in case of an emergency; (2) privacy safeguards that would prioritize individual rights against surveillance demands of population health; (3) AI accountability of AI-based decision support systems; and (4) digital equity so that technology would support and not widen health inequalities.[42]

The law must require privacy-protective surveillance systems that do have sunset clauses, minimization of data and no secondary use without consent. Health data governance standards should be internationalized to help in cross-border research and surveillance and guarantee that the rights of an individual are not violated.[43]

E. Community Engagement and Trust Building

One of COVID-19's most important learning is that people need to trust the government and cooperate as part of effective pandemic response, and this cooperation cannot be provided by legal authority only.[44] The new systems of governance should institutionalize community involvement by: making community advisory boards to the government departments in charge of the public health a legal requirement; making it a requirement that risk

[41] NAM, *National Plan for Health Workforce Well-Being* (2022).

[42] I. Glenn Cohen, Ruben Amarasingham, et al., 'The Legal and Ethical Concerns That Arise from Using Complex Predictive Analytics in Health Care' (2014) 33(7) *Health Affairs* 1139.

[43] Barbara J. Evans, 'Much Ado About Data Ownership' (2011) 25(1) *Harvard Journal Of Law & Technology* 69.

[44] Heidi J. Larson, 'A Call to Arms: Helping Family, Friends and Communities Navigate the COVID-19 Infodemic' (2020) 20(8) *Nature Reviews Immunology* 449-450.

communication be culturally appropriate; making it a requirement that community input be included in policy formulation; and making it an investment in community health worker programs that bridge the formal health systems and communities.

Specific attention should be paid to risk communication governance. Clarity of statutory demands of transparent and science-based public communication; processes of correcting misinformation and respecting free speech; and structures to coordinate messaging at the governmental levels can help to limit confusion and instil confidence.[45]

5. Implementation Framework and Pathways Forward

A. Sequencing and Prioritization

Strategic sequencing is mandatory considering the scope of reforms required. Short-term priorities (2024-2026) should involve: completion of the Pandemic Treaty negotiations and powerful provisions; creation of the Pandemic Fund and sufficient resources; introduction of upgrades of surveillance systems in high-risk areas; and introduction of reformed emergency powers bills in willing jurisdictions.

Medium-term priorities (2026-2028) will cover; national legislative changes to emergency authorities and health governance systems; establishment of international coordination systems; investing in health system resilience and training reformed governance systems.

The following are long-term priorities (2028–2032): institutionalization of the revised international health architecture; comprehensive health system transformation toward universal coverage; cultural shift in health governance toward transparency and community engagement; and constitutional reforms where necessary to clarify authority and protect rights.

B. Political Economy of Reform

Political economy issues are challenging governance reform in health. Reform of emergency powers might attract opposition among executives who are not willing to limit their powers.

[45] Peter M. Sandman, *Effective COVID-19 Crisis Communication*, (Center For Infectious Disease Research And Policy 2020); Joshua M. Sharfstein, Scott J. Becker, 'Diagnostic Testing for the Novel Coronavirus' (2020) 323(15) *JAMA* 1437-1438.

International reforms face the issue of sovereignty and the rivalry between great powers. The reforms in resource allocation confront nationalistic emotions and pharmaceutical interests.[46]

Reform needs a coalition building that integrates different interests to become successful. The issue of sovereignty can be addressed by emphasizing the fact that the world is better prepared in case of a disaster. Justifying that rights protection and economic recovery are not conflicting values but complementary is one way of creating support to balanced emergency structures. The cooperation may be achieved by involving the private sector as partners in preparedness as opposed to enemies.[47]

C. Monitoring and Adaptive Governance

The implementation of reforms should be managed in the form of adaptive management. Mid-course corrections can be made by setting up international and national monitoring systems with frequent reporting requirements. The performance metrics should also evaluate the response to the outbreaks as well as the preparedness investments, equity outcomes, and presidential rights protections.[48]

Adaptive governance also implies the acknowledgement of the uncertainty. The next pandemics might not be like the COVID-19, hence need the loose frameworks without strict rules. There is a need to have learning systems that replicate lessons, share best practices, and develop governance strategies.[49]

6. Conclusion

The COVID-19 pandemic demonstrated that no health governance systems in the world was adequately prepared to handle a high consequences pathogen taking off at an alarming speed. Laws were weak in creating a balance between power to save lives and protection of rights. There was poor coordination of mechanisms. There was inequity on resource allocation and

[46] Daniel W. Drezner, 'The Realist Tradition in American Public Opinion' (2008) 6(1) *Perspectives On Politics* 51.

[47] Qingming Huang, 'The Pandemic and the Transformation of Liberal International Order' (2020) 26(1) *Journal Of Chinese Political Science* 1.

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inefficiency. There was poor accountability or none whatsoever. International collaboration collapsed at the time it was required.

But this crisis is also offering an opportunity to change in a way never seen before. Radical transformation is made possible by the political interest in pandemic preparation, the resources being raised by initiatives like the Pandemic Fund, and the treaty negotiations taking place at WHO. The lessons are obvious: successful health governance involves binding legal commitments, nationally and internationally; strong institutions featuring a clear power structure and sufficient resources; cross-border and cross-sectorial coordination systems; equity as a driving organizing principle, rather than an afterthought; and mechanisms of accountability that would ensure that governance serves the people's health without compromising human rights and democratic principles.

The way to go is to act on each level: citizens need to participate in democratic mechanisms emphasizing to demand accountability; governments of the countries will need to change the legislation and invest in preparedness, international institutions need to be re-empowered and strengthened, civil society needs to keep a watchful eye over the protection of rights, and the scientific community needs to keep developing knowledge and be responsively involved in the work of the policy makers. Reimagining of health governance has started. The future of the world in its next major health crisis will be in the success or failure of it.